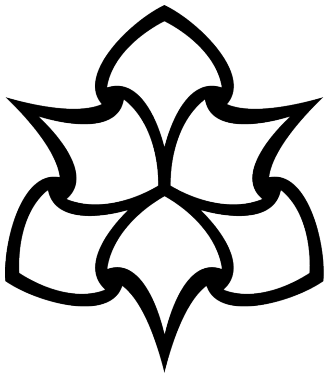

Where the ethical action is

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Received 7 October 2021
Accepted 12 December 2021

ABSTRACT

It is common to think of medical and ethical modes of thought as different in kind. In such terms, some clinical situations are made more complicated by an additional ethical component. Against this picture, we propose that medical and ethical modes of thought are not different in kind, but merely different aspects of what it means to be human. We further propose that clinicians are uniquely positioned to synthesise these two aspects without prior knowledge of philosophical ethics.

WHAT IS THE ADDITIONAL ETHICAL COMPONENT?

It is common to think of medical and ethical modes of thought as different in kind, with different criteria for expertise. Thought of in such terms, some clinical situations are made more complicated by an additional ethical component. Understanding this additional component requires an additional way of thinking, which requires new training. It is not enough to be a doctor, you must be a trained ethicist too.

Let us begin with this picture of the ethical as an additional component that requires a different kind of expertise. We will do this by considering two answers to the question, 'What are you thinking about, doc?': (A1) 'Whether Mary has pneumonia'. (A2) 'Whether Jim should tell his children about his diagnosis of autosomal dominant polycystic kidney disease'. While both answers specify decisions to be made, the first seems to be about a medical decision, regarding a diagnosis, while the second, in light of our opening remarks, seems more complicated. What does the second involve that the first does not? We might answer, 'It involves a decision the patient must make based on what they value'.

So, we might be here tempted to invoke an old classification: the first answer is to do with fact, the second with value. Thus, the additional ethical component seems to be 'anything to do with value'. In these terms, we might further be tempted to suppose that we have here a contrast between an example in which there is an objectively right—medical—answer to whether Mary has pneumonia, but no objectively right—ethical—answer to whether Jim should tell his children about his diagnosis of autosomal dominant polycystic kidney disease. The latter, it might be thought, is a question of value judgement; some might even say it is a registration of personal preference. From the perspective of medical ethics, it is commonly held that one of the clinician's tasks in this situation is to interpret Jim's goals and values (perhaps balanced against the goals and values of society) in order to help him make a good decision. Because there is purportedly no objectively right answer, clinicians can find these ethical issues messy and unresolvable.[1 2] At this stage, anyone with a passing interest in philosophy may well be seeking to interject with the philosopher's 'but!'. What we have hitherto referred to as common is in reality no longer so. The dichotomy we have briefly laid out is not one that is widely endorsed in the philosophical literature beyond bioethics narrowly construed. Values, rather than being mere questions of personal preference, are generally considered integral to the process of knowing.[3–7]

Let us return to the seemingly simple case of Mary's diagnosis—example (1). After asking Mary to describe her symptoms, her General Practitioner (GP), Dr Clarke, takes her temperature and measures her blood oxygen levels with an oximeter. These results may well suggest that Mary has pneumonia, but Dr Clarke cannot be sure; the aetiological agent responsible for community acquired pneumonia is only established in under one-third of cases. Nevertheless, Dr Clarke's clinical judgement is that Mary has low severity pneumonia and prescribes a course of amoxicillin to be started straight away. For patients of Mary's age, pneumonia can be dangerous, so Dr Clarke wants to make sure this does not develop into something more severe that could need hospital admission. Reflecting on this situation, we can start to see that thinking of Mary's diagnosis as merely an objective fact might not be so straightforward.

Given in a primary care setting, Dr Clarke cannot easily (and does not need to) establish the aetiological agent responsible for the pneumonia, she needs criteria by which she can assess the evidence available. For example, even if the temperature and blood oxygen levels are borderline, Dr Clarke is likely to err towards a positive diagnosis. She will apply the criteria of care, insofar as she would rather be wrong about a positive diagnosis than she would about a negative diagnosis. Dr Clarke's diagnosis that Mary has pneumonia could be considered reasonable or even conventional by modern medical standards, but it nonetheless is not simply an objective fact. Care is a value that informs normative judgements about how to reason. Privileging competing values, such as societal cost-effectiveness or prioritisation of young patients, could have led to a different 'fact' about whether Mary has pneumonia. Put this way, it seems clear that even this situation, which we first thought simply related to medical data, involves (or presupposes) evaluative considerations, which are not mere preferences, but rather judgements based on experience. Data and values, it seems, are interwoven. In our example, we might say that the value judgement confers diagnostic status on or provides relevance criteria for the data obtained from the thermometer and the oximeter. Values are involved in the determination of what is treated as a medical fact.

To cite: Hardman D, Hutchinson P. *J Med Ethics* Epub ahead of print: [please include Day Month Year]. doi:10.1136/medethics-2021-107925

Returning to example (2), involving Jim, further shows that data, fact and value might not be so easily disentangled. Autosomal dominant polycystic kidney disease is caused by a genetic fault that causes cysts to grow in the kidneys. A child has a 50% chance of developing the disease if one of their parents has the faulty gene. There is currently no treatment to stop it developing, but symptoms do not generally occur until later in life. Screening is available but is not entirely accurate and may not detect the disease. A key component in Jim's decision to inform his children might, therefore, be the quality of the screening available. The decision depends on the quality of the medical evidence available and the ability to act on that evidence if it is of decent quality. If the tests are unreliable and the treatment is often ineffective, then this will figure in Jim's deliberations. Jim's 'moral end', his ethical objectives, might be shifted by the means available to achieve that end or realise those objectives. Arriving here, we were right to see that there is something *like* an ethical component in this situation, but at the same time we want to say that it is less clear now that 'component' is the right term. For our observations have brought out the extent to which values and data are not merely intertwined, like two discreet but tangled threads, but serve to confer status and situational relevance on each other. Value judgements about the role of medicine confer diagnostic status and relevance criteria to Mary's data. Knowledge about the accuracy of tests, and the ability to cure the kidney disease, frame Jim's moral deliberations in ways that have direct bearing on the outcome of those deliberations.

Arriving at this point in our reflections, we have moved away from the common thought with which we opened, of medical and ethical modes of thought being different in kind, with different criteria for expertise. As we remarked at the outset, this served to complicate clinical situations because it meant thinking ethically involved a new way of thinking, which in turn demanded additional—ethical—training. However, having reflected on our examples and having seen the extent to which the medical and the ethical are intertwined and mutually transformative, the question is raised as to how we should now conceive the merely medical situation. Our picture of the ethics complicating such situations was predicated on the *optionality* of ethics in clinical situations, whereas we now see, based on our examples, that far from being additive the ethical is already interwoven into the medical: the good doctor already delicately weaves the ethical and the medical in the exercise of their distinctively clinical practical judgement. It seems we had better back up and ask a simpler question, 'What is a medical situation?'

WHAT IS A MEDICAL SITUATION?

The blurring of medical and ethical modes of thought has made it more difficult to analyse clearly what is distinctively medical. It can be difficult to know how to proceed except to look at some more situations we think of as clinical.

(3) Mal has a follow-up appointment with his oncologist, Dr Powell. He has recently been diagnosed with thyroid cancer, which has spread from his thyroid gland to other parts of his neck and nearby lymph nodes. Mal is in his mid-70s and otherwise healthy and active for his age.

'How are you holding up Mal?' asks Dr Powell.

'Alright doc, you know. Just want to talk through the treatment options today really.'

'Sure. As we discussed, the first thing we need to do is remove the gland and some lymph nodes. We will then employ radiation therapy after the surgery.'

'Right, I see, yep. I've been doing a bit of reading on this doc, about some alternative treatments.'

'Right, yes, sure. Some of those treatments can be really useful to cope with side effects. A couple of my patients have really benefited from acupuncture, for example. I think that could be a good idea Mal.'

'No, sorry doc. I don't mean that. A friend of mine knew someone who had exactly what I have and cured it using natural medicines, without all this dangerous radiation. I'm getting on as it is doc – I don't want my last years spent laid up in a hospital bed getting zapped.'

(4) Shami is in her mid-60s and books an appointment to see her doctor, Dr Gopal. Shami has been forgetting things recently and is worried what this might mean, especially as her late father suffered from dementia. After a short examination and discussion—all they have time for in this consultation—Shami wants to talk more about what the prognosis could be and what this might mean for her. However, Dr Gopal deflects this discussion, instead focussing on the evidence that, 'only about 5 percent of people with mild cognitive impairment such as you seem to have will progress to dementia each year. And about 60 percent of people do not see their cognitive function decline further, some may even improve'.

In example (3), Dr Powell initially considers that, as the survival rate for thyroid cancer is much better than for another advanced cancers, there does not seem much debate on the correct treatment approach. When Mal introduces the idea of alternative treatments, Dr Powell assumes Mal means to complement the standard approach of modern medicine. On hearing Mal means such treatments as a replacement, it is reasonable to assume that Dr Powell's task is to persuade Mal that he has made a mistake. However, although it may be that Mal is mistaken about the biological effects of alternative treatments for thyroid cancer, there are other, more understandable, criteria to consider. Mal talks of not wanting to be laid up in a hospital bed. He may fear that by undergoing a long period of modern medical treatment of surgery followed by radiotherapy with associated deleterious side effects, he will miss out on what little time he has left with his grandchildren. Even if Mal can be persuaded that the standard treatment is the right approach, this decision will include weighing up factors such as the effect on his quality of life, which is influenced by his personal and family circumstances, what he considers important and how he views the way in which he wants to approach what is left of his life. Any treatment decision must thus involve decisions that we ordinarily conceive of as ethical. In line with our prior reflections, if we consider the situation coherently we cannot easily separate the medical from the ethical. If we want the 'mere' medical situation—where we think of 'the medical' as a clinical situation stripped of all ethical considerations—it seems we must *actively disregard* the ethical in some way. In example (4), the medical and ethical again seem entangled; there is some uncertainty and Shami is understandably worried about what might be happening. In this instance, Dr Gopal could herself be interpreted as actively disregarding (or at least postponing) the ethical by focussing on the available prognostic statistics. In this example, therefore, we see that the process of actively disregarding the ethical is not just something one can do when trying to make sense of an abstract situation, but

an activity one can do to make sense of an ongoing situation one is involved in.

In examples (3) and (4), the merely medical situation does not appear by itself; it is only made manifest by actively disregarding, trying to strip away, the ethical in some way. Another way to put this is that the situation is made medical by regarding it from a particular, medical but not ethical, perspective. But what sort of perspective is 'medical but not ethical'? We cannot invoke 'fact' or 'value' as intelligibly separate perspectives because we have made clear the two are inextricably entangled. One answer that springs to mind is that to regard a situation as medical but not ethical is to regard it from a purely biological perspective. Perhaps here is an answer that seems to make sense. A situation is merely medical when one explains it from a biological perspective, thereby highlighting its biological aspects and overlooking the ethical aspects.

We belatedly have a picture to get us started. Merely medical situations occur in the biological order of things—that is, they are conceived as *bio*medical—grounded in our complex and sophisticated understanding of science; they are only made possible by adopting such a perspective, under what we could call an aspect. It is clear that this picture is different to the picture we started with. We started this paper with a picture that depicted medical situations as primary, made more complex by an additional ethical component. What we now see is something like the converse: we need some considerable education to make sense of a medical situation. To see a situation under a purely biomedical aspect requires training. When we began, we wanted to place the messy and unresolvable ethical component on top of the clearer, resolvable medical one. But now it seems that if we want the ethical, we cannot start from the medical. If we ask, out of the blue, 'What is the additional ethical component?', we get misled. Asking this question assumes that the ethical is something discrete and additional to the medical. Whereas the medical is merely an aspect of the situation—which too has an integral ethical aspect—made possible by the biological perspective which is accessed by having undergone significant formal training (going to medical school) and then being motivated to view the situation in such a way (needing to diagnose and treat the patient). This will not give us a starting point from which to add an additional ethical component; such an aspect is one from which an ethical component could not arise. We must, therefore, change the question again and instead ask simply, 'What is an ethical situation?'

WHAT IS AN ETHICAL SITUATION?

In trying to answer this question, let us consider our examples from the simpler standpoint of aspects. In looking at Mary's case, seeing the ethical aspect involves considering how Dr Clarke conceives of and values the role of medicine in society. In Jim's case, it involves being attuned to how his consideration of his situation foregrounds his relationship with his daughters, notably his desire to shield them from harm and discomfort. In Mal's case, it involves considering his personal and family circumstances and how he assesses the wider effects of treatment on his quality of life. And in Shami's case, it involves understanding how her experience of caring for her father influences how she evaluates symptoms and interacts with her doctor.

Thinking through these examples, we see that an ethical situation is grounded in particular, everyday concerns, which are often resolved in a shared and negotiated cultural background.[8] [i] The ethical is thus merely an aspect of the situation made clear by the everyday perspective afforded to us as individuals living with one another in society. Our difficulty at the outset was thinking of 'ethics' and 'values' as philosophical words, used in a very theoretical or general way. Given that seeing a situation under a medical aspect requires specialised biological knowledge acquired through training, clinicians can most usefully regard a situation in that way. But such training does not have to estrange clinicians from everyday human concerns, such that they think ethical situations complex and uncertain, and medical situations clear and distinct. A misleading position could be developed through medical training because ethical decisions are often discussed in suspiciously unscientific terms, while medical decisions are often discussed in a more straightforward, scientific way. But, as is too obvious to note, clinicians encounter life's challenges just as their patients do; in any case, any such perception would soon be discharged on contact with clinical practice.

This is not to say that clinicians are, by virtue of being fellow citizens, experts in their patients' lives. Given the prevalent sociocultural differences between clinicians (notably doctors) and many of their patients, this is manifestly not the case. However, these barriers, we argue, are not overcome by recourse to and application of an ethical theory, but by clinicians cultivating a greater understanding of and sensitivity towards their patients' everyday lives.[11] [ii] This cultivation—something most clinicians would readily agree with—could be promoted by adapting the teaching of ethics in medical schools. Rather than presenting the notion of 'thinking ethically' as a process informed by the application of and reflection on the competing merits of special principles, more focus could be given to activities that ground ethics in everyday human concerns; for example, providing more exposure to patient accounts of their own illness experience, more opportunities for active rehearsal and improvisation in simulated clinical settings, and more exposure to medical literature and theatre.[12 13]

DIFFERENT ASPECTS NOT A DIFFERENCE IN KIND

Inverting our starting position, we could, if pushed, view the medical mode of thought complex and specialised and the ethical one plain and simple. But perhaps we do not even want to say that because this distinction is given to us by the misleading picture we adopted at the outset. Medical and ethical modes of thought do not differ in kind, they are merely different aspects of what it means to be human. Clinicians are uniquely positioned to synthesise these two aspects—without prior knowledge of philosophical ethics—because they are able to see ethical situations in medical situations and vice versa. That is where the ethical action is in the clinic.[iii]

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[i] A similar common-sense position on ethics can be interpreted in recent work on person-centred care. Although initial versions of the framework have been critiqued for being overly individualistic (see Hardman and Ongaro[9] for a critique), recent versions focus on intersubjective relationships and interactions, rather than individual persons.[10]

[ii] Importantly, our argument should not be interpreted as proposing a general definition of ethics or the ethical. Instead, we just conclude that when talking about the 'medical' and the 'ethical' in a clinical situation, it is useful to conceive of the former as seeing the situation under a biological aspect and the latter as seeing the situation under an everyday aspect.

[iii] The title and philosophical approach of this paper are inspired by Frank Ebersole's essay, 'Where the action is'.[14]

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Contributors Both authors contributed to conceptualisation, formal analysis, writing of the original draft and reviewing and editing. DH is the author responsible for the overall content as the guarantor.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval This study does not involve human participants.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement No data are available.

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